Kansas Department of Health and Environment
Community Health Systems

Kansas Department of Health and Environment
J-1 Visa Waiver Program

Form must be fully complete before submission of request. Send completed form to primarycare@kdheks.gov

Advance Notification Request for J-1 Visa Waiver

First Name: _____ Last Name:_____

Female: ____ Male:____ Dept. of State Case #:_____ ECFMG #: _____

Physician Email: _____

Employer: _____

CEO: _____ Phone #: _____Email: _____

Contact Person: _____ Phone #: _____Email: _____

Employer Business Address: _____

City: _____ State: _____ Zip Code: _____

Street Address of Facility/Practice Site: _____

City: _____ State: _____ Zip Code: _____

If the physician will be working in more than one facility/practice sites, provide a list of all physical locations as an attachment to this form.

Select the Best Appropriate Category for the Physician, based descriptions provided below. Select only one option.

☐ Physician who is board certified in Family Practice, General Internal Medicine, General Pediatrics, Obstetrics/ Gynecology, Emergency Medicine or Psychiatry; and will be working in an outpatient, ambulatory care setting.

☑ Physician who is board certified in a primary care specialty (listed above) and will be serving in the capacity as a Hospitalist; OR Physician who is board certified in a non-primary care specialty directly related to the management of time critical diagnoses (STEMi, Stroke, and Trauma).

☑ Physician who is board certified in non-primary care specialty that directly supports the coordination of care for patients with chronic disease (e.g., diabetes, heart disease).

☑ Physician who is board certified in all other specialties.

List Physician's Specialty: _____.
(Optional) Additional Information as it relates to the physician specialty. (Limit 100 words)

_____

_____

_____

_____

_____

Attorney Name: _____ Law Firm _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Point of Contact: _____

Phone #: _____ Email: _____

Save Form